

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015204
STATE FILE NUMBER
2 2850

FILED MAY 1 1959

Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3235a Delmar Blvd.	
3. NAME OF DECEASED (Type or print) First GARRETT Middle JONES Last JONES		4. DATE OF DEATH Month March Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1949
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		9b. AGE (In years last birthday) 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Theodore Jones		13b. MOTHER'S MAIDEN NAME Erma Frison	
14. NAME OF HUSBAND OR WIFE --		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Erma Jones Address 3235a Delmar Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage of the Brain DUE TO (b) Internal Hemorrhage DUE TO (c) Subarachnoid Hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Enter only one condition per line for (a), (b), and (c).) Cardiac arrest by one Thrombus		INTERVAL BETWEEN ONSET AND DEATH 1	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour 7:35 Month 3 Day 14 Year 59		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, or office bldg., etc.) 3337 Delmar Avenue, about 7:35 p.m., March 14, 1959.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION St Louis Mo	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 900 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Joseph E. Quinn (Deputy Registrar)	
22b. ADDRESS 1300 Clark		22c. DATE SIGNED 3/20/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 23, 1959	
23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR J. H. RANDLE & SON		25. DATE RECD. BY LOCAL REG. MAR 20 '59	
26. REGISTRAR'S SIGNATURE Harold Smith M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ethel K. Harris*

Licensed Embalmer No. *4458*
P. O. Address *4181 Washm*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.